### Hormone replacement therapy for menopausal patients: FAQ

**GENERAL: What do I really need to know about the Women’s Health Initiative?**

The WHI objective was to assess the overall major health risks and benefits of menopausal hormone therapy—i.e., not how they worked for symptoms, but whether they actually improved long-term health outcomes in women. There were two arms: The estrogen-only arm (for women s/p hysterectomy), and the estrogen-plus-progesterone arm. Both were stopped early due to overall greater harm than benefit. Both clearly demonstrated the risks of hormone replacement in older postmenopausal women, namely breast cancer, VTE, and stroke.

You should know these two limitations of the WHI studies: 1) They were both short-term studies (by design and by early stopping), and some of the risks and benefits that appeared in the short-term were not born out in longer-term follow-up; and 2) The women in the WHI were mostly older than 60, and this is *not* the age group that typicall presents with new-onset menopausal symptoms. Women in their late 40s and early 50s (the most common age to seek medical therapy for menopausal symptoms) should be reassured that the absolute risk of health complications in otherwise healthy women their age who take hormones for less than five years is actually quite low.

**SYMPTOMS: What are the symptoms of menopause? What are “vasomotor symptoms?” And which symptoms warrant hormone replacement?**

The full range of therapies for menopausal symptoms are beyond the scope of this little handout, but in brief:

* Vaginal dryness: if this is the primary/only symptom, consider a vaginal estrogen cream instead of systemic treatment.
* Mood changes /depression: Best treated by a low-dose antidepressant like Paxil rather than hormones.
* Osteoporosis: First, DEXA scan (which can be appropriate in women <65 years if you are concerned about risk of falls or fractures). Then, based on Z-score 🡪 consider bisphosphonates.
* Dementia/confusion: Hormones are not indicated for this.

Vasomotor symptoms (i.e. hot flashes or “flushes”) are extremely bothersome to some women. They can be associated with night sweats. These are the symptoms targeted by hormone replacement (and the only indication for which hormone replacement is FDA approved and recommended by the major medical societies).

**EPIDEMIOLOGY/RISKS:**

**Which women are most likely to get hot flashes?** Risk factors for experiencing hot flashes include obesity, smoking, low socioeconomic status, and African-American race. (SWAN study).

**Which women can I tell right off the bat that they *can’t* have hormone replacement?**

Women with a personal history of breast cancer, CAD, VTE, stroke, or active liver disease cannot receive estrogen products. Women who are at high risk for these conditions (e.g. strong family history of breast cancer, alcoholism, smoker) also should not receive estrogen.

**Anyone else I should advise against taking estrogen?**

In general, the risks of hormone replacement probably outweigh the benefits in women over 60, or in women with only mild hot flashes. Do NOT use hormone therapy to prevent heart attacks or strokes. Do NOT use hormone therapy to prevent memory loss or Alzheimer’s disease.

**TREATMENT:**

**Who should get estrogen alone, and who should get estrogen + progesterone?**

Simple:

Women with a uterus 🡪 estrogen + progesterone.

Women *without* a uterus (for any reason)🡪 estrogen alone.

**How should I prescribe the hormones?**

One approach would be:

ESTROGEN:

* Start with **transdermal estradiol 0.025 mg/day**, increase monthly as needed if hot flashes persist 🡪 0.0375 mg/day 🡪 0.05 mg/day, **or:**
* **Oral estradiol (0.5 mg/day)** if women prefer to take a pill for financial or other reasons

PROGESTERONE:

* **Micronized progesterone 200 mg/day**, 12 days/month. **Or 100 mg/day continuously** (for women who are a few years into menopause and are at less of a risk of continuous bleeding); **or:**
* **Mirena** is also an acceptable alternative for continuous progesterone replacement.

**What about patients who want to stop hormone replacement?**

* Most stop without help from their doctor and have no problems.
* A gradual taper (reducing by one pill per week, or using dose-reduced patches one week at a time) is advised for women who had severe hot flashes.

**Key references:**

* WHI—The estrogen + progesterone study: <http://jama.jamanetwork.com/article.aspx?articleid=195120>
* WHI: The estrogen only study: <http://jama.jamanetwork.com/article.aspx?articleid=198540>
* [www.swanstudy.org](http://www.swanstudy.org) : Study of Women’s Health Across the Nation (SWAN), an ongoing cohort study evaluating longitudinal changes in biological, behavioral, and psychosocial parameters in menopausal women. Funded by NIH and others.
* Best UpToDate articles to summarize for you: Treatment of menopausal symptoms with hormone therapy; Menopausal hormone therapy: Risks and benefits.

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**Hormone replacement for menopause: Information for patients**

Short-term hormone replacement (estrogen +/- progesterone) is currently a recommended treatment for hot flashes in menopause. Hormone replacement is generally considered safe for women who have no personal history or known high risk of cancer, blood clots, stroke, liver disease, or coronary artery disease.

You have probably heard about various risks associated with hormone replacement. Here are some important points to know:

* *If you have a uterus, you must always use progesterone with estrogen. Using estrogen alone seriously increases your risk of uterine cancer.*
* Women who do not have a uterus should not receive progesterone. There is no health benefit to taking progesterone in these women.
* Most women should take estrogen continuously, and progesterone cyclically (12 days on, then 16 days off), to prevent irregular, unpredictable bleeding. If you stopped having your period more than two years ago, you can probably take continuous progesterone without worrying about bleeding.
* I prescribe estrogen in patch or pill form. I recommend trying the patch first (because it reaches lower blood concentrations and has lower risk for causing blood clots and stroke). I prescribe progesterone as a pill.
* If you don’t suffer much from hot flashes, but are concerned about vaginal dryness, mood changes, joint aches and pains, or memory loss (all other symptoms of menopause), then I will NOT recommend hormone replacement.
* Hormone replacement is NOT recommended for preventing heart disease, bone loss, or cancer. It is only recommended as a short-term treatment for menopausal hot flashes.
* I recommend using hormone replacement for 2-3 years, if it is helping your symptoms. Five years is the longest amount of time you may use hormone replacement for hot flashes. Longer use appears to increase the risk of breast cancer. When you are ready to stop, it is usually easy to stop without tapering. Most women use hormone replacement for less than a year, and many stop without the help of their doctor.
* Because you may change where you live or where you receive medical care over the next five years, *it is your responsibility to write down the date you start your hormone replacement and the date by which you should stop. (E.g., a woman who starts taking hormones in 2010 must stop by 2015, unless specifically advised otherwise by their doctor.)*
* Alternatives treatments for hot flashes: Some women use soy and soy products, or the herb black cohosh, as alternatives to estrogen therapy. Generally, very little is known about the safety of these alternatives, especially for women with a history of cancer, stroke, or blood clots. But we can talk more about whether they’re safe for you.

More information online: [*http://www.womenshealth.gov/publications/our-publications/fact-sheet/menopause-treatment.html*](http://www.womenshealth.gov/publications/our-publications/fact-sheet/menopause-treatment.html)

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**Assessment/Plan:**

I have discussed with the patient my approach to treating menopause symptoms—primarily hot flashes—in women *without history of cancer, CAD, stroke, or VTE:*

* Transdermal estrogen is first-line treatment for hot flashes, as it has lower risk of VTE and stroke compared to oral estrogen. I recommend starting with **transdermal estradiol 0.025 mg/day patch**, to be increased to 0.037 mg/day after one month if hot flashes are still present, and if symptoms are still not relieved one month later, to 0.05 mg/day.
* Risk of VTE or stroke is very low in otherwise healthy, young postmenopausal women. Therefore, **if the patient prefers** (either for financial or other reasons) she can take **oral 17-beta estradiol 0.5 mg/day**.
* **For all women with a uterus, I add cyclic (12 days per month) micronized progesterone, 200 mg/day**, to prevent the increased risk of endometrial hyperplasia and cancer from using estrogen alone. Women who have undergone hysterectomy should not receive progestin, as there are no other health benefits of progestin for these patients. **A Mirena IUD is an acceptable off-label progesterone alternative for most menopausal women.**
* Based on these recommendations, she is interested in \*\*\*.